PREGNANCY QUESTIONNAIRE

Patient Name_____ **Date**_____

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ( ) Yes ( ) No If no, please tell us about your previous pregnancy/birth experiences (Durations, Interventions, etc)

Do you plan to follow the same plan as your previous pregnancy/delivery? ( ) Yes ( ) No If no, what would you like to change?

CONCEPTION AND EARLY PREGNANCY

When is your expected due date?

Did you have any difficulty conceiving? ( ) Yes ( ) No Please explain:

Have you ever used any form of hormonal oral contraceptive? ( ) Yes ( ) No If yes, which ones and for how long?

When was you r last menstrual cycle?

What was your pre-pregnancy weight? Current weight?

Have you experienced morning sickness? ( ) Yes ( ) No Please explain:

CURRENT HEALTH CONDITIONS

What type of exercise are you currently performing?

Are you working with a trainer experienced in prenatal exercise/yoga?

Please tell us about your current diet and any restrictions:

Have you taken any medications or supplements during pregnancy? ( ) Yes ( ) No Please explain:

Have you had any slips, falls, accidents or traumas during this pregnancy? ( ) Yes ( ) No Please explain:

Do you have another small child at home that you carry frequently? ( ) Yes ( ) No Please explain:

Do you have any major emotional stressors during your pregnancy? ( ) Yes ( ) No Please explain: